

LETTERS TO THE EDITOR

Scope

Heart welcomes letters commenting on papers published in the journal in the previous six months. Topics not related to papers published earlier in the journal may be introduced as a letter: letters reporting original data may be sent for peer review.

Presentation

Letters should be:

- not more than 600 words and six references in length
- typed in double spacing (fax copies and paper copy only)
- signed by all authors.

They may contain short tables or a small figure. **Please send a copy of your letter on disk.** Full instructions to authors appear in the January 1997 issue of *Heart* (page 89).

Prospective relations between *Helicobacter pylori* infection, coronary heart disease and stroke in middle-aged men

SIR,—In our nested case-control study of *Helicobacter pylori* infection and coronary heart disease,¹ based on the British Regional Heart Study cohort, men with pre-existing coronary heart disease were unintentionally under-represented among the controls selected (4% *v* 21% expected). This problem has been documented in the *Lancet*² in relation to a parallel study of the relation between homocysteine and stroke.³ However, the results of the study of *H pylori* and its associations with coronary heart disease and stroke are not materially affected by this under-representation. This is emphasised by the results presented in the paper showing that the odds ratio associated with *H pylori* infection for coronary heart disease was very similar if men with pre-existing disease were completely excluded. Our conclusion therefore remains unchanged.

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- 1 Whincup PH, Mendall MA, Perry IJ, Strachan DP, Walker M. Prospective relations between *Helicobacter pylori* infection, coronary heart disease and stroke in middle-aged men. *Heart* 1996;75:568–72.
- 2 Perry IJ. Serum homocysteine and risk of stroke [letter]. *Lancet* 1996;348:1526.
- 3 Perry IJ, Refsum H, Morris RW, Ebrahim SB, Ueland PM, Shaper AG. Prospective study of serum total homocysteine concentration and risk of stroke in middle-aged British men. *Lancet* 1995;346:1395–8.

Probable right ventricular dysplasia and patent foramen ovale presenting with cyanosis and clubbing in a patient with characteristics of Noonan syndrome

SIR,—I report additional information on a case described by myself and Da Costa.¹ The patient, who presented with cyanosis and clubbing, was described as having *probable* right ventricular dysplasia associated with

patent foramen ovale. She also had characteristics of Noonan syndrome. Right ventricular endomyocardial biopsy specimens showed fibre hypertrophy, vacuolation, and degeneration with fine interstitial fibrosis; however, fatty infiltration was not seen. Despite the presence of one major criterion for diagnosis of right ventricular dysplasia (severe dilatation and reduced ejection fraction of the right ventricle without left ventricular impairment), and one minor criterion (T wave inversion in leads V1–V4 on ECG), there were insufficient criteria for definitive diagnosis of right ventricular dysplasia.²

The original report pointed out that the patchy nature of fatty infiltration in the right ventricle can result in failure of endomyocardial biopsies to sample an area of fatty infiltration. Thus, the criteria used for diagnosis often prevents diagnosis during the patient's life; they are later confirmed at post mortem examination to have right ventricular dysplasia.

Our patient has since undergone right ventricular cardiomyopathy with closure of the foramen ovale (by Professor Sir Magdi Yacoub) with clinical benefit. Transmural biopsies taken at that time from the left ventricle were normal. Right ventricular biopsies showed no myocardial tissue but extensive fibrous and fatty tissue (personal communication, Dr M Burke, consultant histopathologist, Mount Vernon Hospital, Middlesbrough). This additional information confirms that the patient satisfied the criteria for a diagnosis of right ventricular dysplasia.

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- 1 Wilmshurst P, Da Costa P. Probable right ventricular dysplasia and patent foramen ovale presenting with cyanosis and clubbing in a patient with characteristics of Noonan syndrome. *Br Heart J* 1995;74:471–5.
- 2 McKenna WJ, Thiene G, Nava A, Fontaliran F, Blomstrom-Lundqvist C, Fontan G, *et al*, on behalf of the Task Force of the Working Group Myocardial and Pericardial Disease of the European Society of Cardiology and of the Scientific Council on Cardiomyopathies of the International Society and Federation of Cardiology, supported by the Schoepfer Association. Diagnosis of arrhythmogenic right ventricular dysplasia/cardiomyopathy. *Br Heart J* 1994;71:215–8.

Echocardiographic evaluation of ventricular diastolic function: implications for treatment

SIR,—In their recent editorial Brecker and Gibson suggest an alternative approach to assessing the effects of treatment in diastolic dysfunction, namely to identify changes in diastolic measurements occurring with treatment that are known to increase exercise tolerance or improve prognosis.¹

Although exercise limitation is the obvious outcome for patients with clinically significant diastolic dysfunction and indeed any functional limitation is likely to be more evident on exercise, nearly all studies report on resting parameters of diastolic performance. Despite increasingly widespread use of stress echocardiographic data in the definition of myocardial ischaemia, systolic dysfunction, and exercise related valve dysfunction, the role of exercise based echocardiographic indices of cardiac relaxation have to date been largely ignored. The reason for this is unclear.

Studies conducted during exercise may

increase our ability to define abnormal relaxation and both link this directly to impairment of exercise capacity and assess the effects of candidate treatments. We have previously assessed the effects of brain natriuretic peptide (BNP) infusion on exercise haemodynamics in isolated diastolic dysfunction.² We found that BNP significantly attenuated the exercise induced rise in pulmonary capillary wedge pressure in patients with diastolic dysfunction. In this study, we used invasive haemodynamic monitoring but it is our belief that exercise diastolic performance can be assessed non-invasively with Doppler echocardiography. To achieve this, non-invasive echocardiographic surrogate measures of ventricular filling pressure on exertion need to be explored and validated.

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- 1 Brecker SJD, Gibson DG. Echocardiographic evaluation of ventricular diastolic function: implications for treatment. *Heart* 1996;76:386–7.
- 2 Clarkson PBM, MacFadyen RJ, Wheeldon NM, MacDonald TM. Effects of brain natriuretic peptide on exercise haemodynamics and neurohormones in isolated diastolic heart failure. *Circulation* 1996;93:2037–42.

CORRECTIONS

Fludrocortisone in the treatment of hypotensive disorders in the elderly

RM Hussain, SJ McIntosh, J Lawson, RA Kenny (*Heart* 1996;76:507–9).

Under "Interventions" in the abstract it should have read: Fludrocortisone in daily doses of 100 µg (72%), 50 µg (27%), and 200 µg (one patient). And not as published.

Effects of increasing flow rate on aortic stenotic indices: evidence from percutaneous transvenous balloon dilatation of the mitral valve in patients with combined aortic and mitral stenosis

T-M Lee, S-F Su, M-F Chen, C-S Liao, Y-T Lee (*Heart* 1996;76:490–4).

Dr Sheng-Fang Su's name was misspelled in the article.

NOTICES

The 1997 Annual Conference of the British Cardiac Society will take place at G-MEX, Manchester from 20–22 May. For further information, please contact the British Cardiac Society, 9 Fitzroy Square, London W1P 5AH. (Tel: +(0) 171 383 3887; fax: +(0) 171 388 0903; e-mail: bcs@rbh.nthames.nhs.uk) or visit <http://www.bcs.rbh.nthames.nhs.uk> on the Internet.

Asian-Pacific Cardiovascular Update will be held from June 5–6 in Hong Kong. For further information, contact Professor JE Sanderson, Department of Medicine, Prince of Wales Hospital, Chinese University of Hong Kong. (e-mail: jesanderson@cuhk.edu.hk).